



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

CHRISTUS ST ELIZABETH HOSPITAL  
c/o HOLLOWAY & GUMBERT  
3701 KIRBY DRIVE, SUITE 1288  
HOUSTON TX 77098-3926

#### **Respondent Name**

ZURICH AMERICAN INSURANCE CO

#### **MFDR Tracking Number**

M4-09-4193-01

#### **Carrier's Austin Representative Box**

Number 19

#### **MFDR Date Received**

DECEMBER 15, 2008

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "As required by law, the Provider billed its usual and customary charges for its services...Per Rule 134.401(c)(6) (A)(i) (iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%... the fees paid by Liberty Mutual Insurance Company do not conform to the reimbursement section of Rule 134.401...In closing, it is the position of the Provider that all charges relating to the admission of the claimant are due and payable and not subject to the improper reductions taken by the carrier in this case. The carrier's position is incorrect and in violation of the ACIHFG."

**Amount in Dispute:** \$27,727.31

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Requestor billed a total of \$75,943.65. The Requestor asserts it is entitled to reimbursement in the amount of \$56,957.74, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges. "

**Response Submitted by:** Flahive, Ogden & Latson

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 13, 2007 through December 19, 2007	Inpatient Hospital Services	\$27,727.31	\$0.00

## ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

#### **Explanation of Benefits**

- 16-Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
- 253-In order to review this charge we will need a copy of the invoice.
- 45-Charges exceed your contracted/legislated fee arrangement.
- 770-Complex bill review.
- 793-Reduction due to PPO contract.
- 812-In order to analyze the attached billing we will need a copy of the itemized billing.

### **Findings**

1. The insurance carrier reduced or denied disputed services with reason code 45 – “Charges exceed your contracted/legislated fee arrangement.” Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Former 28 Texas Administrative Code §134.401(c)(5), which requires that "When the following ICD-9 diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate: (A) Trauma (ICD-9 codes 800.0-959.50); (B) Burns (ICD-9 codes 940-949.9); and (C) Human Immunodeficiency Virus (HIV) (ICD-9 codes 042-044.9)." Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 805.2. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. Former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
  - The requestor's asserts that “As required by law, the Provider billed its usual and customary charges for its services...Per Rule 134.401(c)(6) (A)(i) (iii), once the bill has reached the minimum stop-loss threshold of \$40K, the entire admission will be paid using the stop-loss reimbursement factor ('SLRF') of 75%... the fees paid by Liberty Mutual Insurance Company do not conform to the reimbursement section of Rule 134.401...In closing, it is the position of the Provider that all charges relating to the admission of the claimant are due and payable and not subject to the improper reductions taken by the carrier in this case.

The carrier's position is incorrect and in violation of the ACIHFG."

- The requestor does not discuss or explain how additional payment of \$27,727.31 would result in a fair and reasonable reimbursement.
- The requestor seeks reimbursement for this admission based upon the stop-loss reimbursement methodology which is not applicable per Division rule at 28 TAC §134.401(c)(6).
- The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The Division has previously found that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the *Acute Care Inpatient Hospital Fee Guideline* adoption preamble which states at 22 Texas Register 6276 (July 4, 1997) that:

"A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

12/16/2013  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**